# EXHIBIT 16

**Best Buy**

**Medical Benefit Program**

**Summary Plan Description of**

**Health Plan 4**

**One of the Choice Plus Health Coverage Options (with Benefit Differential)**

**for Eligible Employees**

**Provider Networks:**

**Within Minnesota you will use the Medica Choice network established by Medica Self-Insured.**

**Within all other locations (except Hawaii and Puerto Rico) you will use the Choice Plus network established by UnitedHealthCare. Eligible Employees living in Hawaii or Puerto Rico may participate in a separate Health Plan for that area.**

**Group Number: 703352**

**Effective Date: April 1, 2009**

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## B. OVERVIEW

The information contained in this section of the Summary provides general information regarding the Program that must be disclosed under ERISA. It is important to remember that this section of the Summary is only an overview. Covered Persons also need to refer to the section that describes a Benefit or particular requirement in detail.

Many words used in this Summary have special meanings. These words are capitalized and are defined in Section 10: *Glossary of Defined Terms*. Use these definitions to best understand this Summary. By applying these definitions, Covered Persons will have a clearer understanding of the coverage described in this Summary.

Language interpretation services will be provided upon request, as needed in connection with the interpretation of this Summary. Please contact Customer Service to make such a request. If this Summary is translated into another language, this written English version governs all coverage decisions.

### General Program Information

ERISA requires the Plan Administrator to disclose certain information about the Program, Best Buy's Flexible Benefits Plan and various entities with responsibilities under the Program and the Flexible Benefits Plan.

#### *Program Name*

The name of the Program that includes Benefits described in this Summary is the "Best Buy Medical Benefit Program."

This Program is part of the Best Buy Flexible Benefits Plan sponsored by Best Buy (the "Flexible Benefits Plan"). The Flexible Benefits Plan includes several group Benefit Programs and a Flexible Spending Program that allows you to pay your share of the cost of this Program and other Benefit Programs by making contributions from your paychecks, on a pre-tax basis for benefit options and coverage of your Covered Dependents (other than Domestic Partners or their Covered Dependent children) that qualify under federal income tax laws.

#### *Sponsoring Employer ("Sponsor") and Address and Telephone Number of Sponsor*

Best Buy Co., Inc. (or "Best Buy")
Best Buy Corporate Campus
7601 Penn Ave. South
Richfield, MN 55423-3645

612-291-1000

#### *Employer Group*

In this Summary, Sponsor and the other employers participating in this Program are called the Employer Group. The Employer Group includes the Sponsor and any of its Affiliates participating in this Program with the consent of the Sponsor's Board of Directors. For this purpose, "Affiliate" means any subsidiary, corporation, partnership or other organization in which Sponsor owns, directly or indirectly, a controlling interest.

A complete list of the Employer Group members participating in this Program at any time may be obtained by Covered Persons on written request to the Plan Administrator. That list is also available for examination by those individuals.

***Plan Administrator, Business Address and Business Telephone Number of Plan Administrator***

Rewards Sponsor Committee
c/o Best Buy
Best Buy Corporate Campus
7601 Penn Ave. South
Richfield, MN 55423-3645

612-291-1000

The members of the Rewards Sponsor Committee are appointed by the Board of Directors of Sponsor. The Rewards Sponsor Committee is the Plan Administrator for the Flexible Benefits Plan, including this Program; and is also the named fiduciary (for ERISA purposes) for the Program and the entire Flexible Benefits Plan.

***Agent for Service of Legal Process***

General Counsel
Best Buy
Best Buy Corporate Campus
7601 Penn Ave. South
Richfield, MN 55423-3645
612-291-1000

***Sponsor's IRS Employer Identification Number (EIN)***

41-0907483

***Plan Year***

The fiscal records of the Program and the Flexible Benefits Plan are maintained on the basis of the Plan Year, which is each twelve-month period that begins on April 1 and ends on the next March 31.

***IRS Plan Number***

501

***Type of Welfare Plan***

Medical

***Type of Administration***

Self-insured by the Employer Group, and administered by Claims Administrators as described below.

Best Buy Enterprise Services, Inc. (a member of the Employer Group) has entered into service agreements, on behalf of the Plan Administrator and Sponsor, with United HealthCare Insurance Company (or "UnitedHealthCare") and Medica Self-Insured. Each of them has agreed to act as a "Claims Administrator" for the Program, on behalf of the Plan Administrator of the Flexible Benefit Plan.

Under those service agreements, each of the Claims Administrators administers and decides Benefit claims and appeals in its service area, and performs a variety of other administrative services with respect to the medical Benefits provided under the Program and described in this Summary. Each of these agreements is for administrative services only, except that the responsibility to decide Benefit claims and appeals is a fiduciary duty under the federal law called "ERISA". Neither of the Claims Administrators insures the delivery or cost of any Benefits under the Program.

Under the service agreement between UnitedHealthCare and Best Buy Enterprise Services, Inc., UnitedHealthCare also administers and decides Prescription Drug Expense Benefits claims and appeals, and performs a variety of other administrative services with respect to the Prescription Drug Expense Benefits

provided under the Program and described in this Summary. The agreement is for administrative services only, except that the responsibility to decide Benefit claims and appeals is a fiduciary duty under ERISA. Neither UnitedHealthCare nor Medica Self-Insured insure the delivery or cost of any Prescription Drug Expense Benefits under the Program.

***Service Areas, Authority and Names and Address of Claims Administrators***

Medica Self-Insured is the Program's Claims Administrator for medical Benefits (other than Prescription Drug Expense Benefits) for Covered Persons who reside within Minnesota.

UnitedHealthCare is the Program's Claims Administrator for medical Benefits for Covered Persons who reside elsewhere within the United States (except Eligible Employees living in Hawaii, who are eligible for separate medical coverage under the Program). Eligible Employees living in Puerto Rico may be eligible for the separate Best Buy Puerto Rico Healthcare Benefits Program.

UnitedHealthCare is also the Program's Claims Administrator for Prescription Drug Expense Benefits for Covered Persons who reside anywhere within the United States, except Eligible Employees living in Hawaii, who are eligible for separate Prescription Drug Expense coverage under the Program. Eligible Employees living in Puerto Rico may be eligible for prescription drug coverage under the separate Best Buy Puerto Rico Healthcare Benefits Program.

The role of each Claims Administrator is to handle the day-to-day administration of the Program's coverage as directed by the Plan Administrator, and to decide Benefit claims and appeals in its service area, through an administrative services agreement described above under the title *Type of Administration*. A Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Flexible Benefits Plan or the Program. A Claims Administrator shall not be responsible for fulfilling any duties or obligations of any member of the Employer Group with respect to the Flexible Benefits Plan or the Program. However, each of the Claims Administrators has been appointed by the Plan Administrator as a fiduciary to decide Benefit claims and appeals under the Program in its service area.

You may contact your Claims Administrator by phone at the Customer Service number on your Medical ID Card or in writing at:

UnitedHealthCare/Medica Self-Insured

P.O. Box 150450
450 Columbus Blvd.
Hartford, CT 06115-0450

***Funding***

Benefits under the Program are paid from the general assets of the Employer Group. Covered Persons may be responsible for a portion of the cost of the coverage provided under the Program. A portion of the cost of coverage for which a Covered Employee is responsible may be paid on a pre-tax basis through the Flexible Spending Program, which is a "cafeteria plan" described in Code Section 125, and is also a part of the Flexible Benefits Plan made available by Sponsor.

***Method of calculating the amount of contribution***

Employee-required contributions to the Employer Group are the Covered Employee's share of Program costs as determined by Sponsor. From time to time, Sponsor will determine the required Employee contributions for reimbursement to the Employer Group and distribute to Eligible Employees a schedule of such required contributions.

**ERISA Information**

**Statement of ERISA Rights**

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") guarantees certain rights and protection to participants of benefit plans and certain other persons. Federal law and regulations require that a "Statement of ERISA Rights" be included in this Summary of Best Buy's Program. For purposes of this Statement of ERISA Rights only, the terms "you" and "your dependents" refer to Covered Employees and Covered Dependents who have such rights and protections under ERISA; and references to "plan" mean this Program, unless the reference can apply only to the entire Flexible Benefits Plan. ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

You may examine, without charge, all plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions, and other documents filed with the Department of Labor. You may examine copies of these documents in the Plan Administrator's office, or you may ask a supervisor where copies of the documents are available.

If you want a personal copy of plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only a reasonable charge for the copies.

You are entitled to receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Program Coverage**

You or your dependents are entitled to continue coverage under the plan if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this Summary for information regarding COBRA continuation coverage rights.

You should be provided a certification of creditable coverage, free of charge, from the plan when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. These individuals, called "fiduciaries," have an obligation to administer the plan prudently and to act in the interest of plan participants and beneficiaries. The named fiduciary for the plan is the Plan Administrator, which is the Rewards Sponsor Committee. No one, including your employer, union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

**Enforce Your Rights**

When you become eligible for payments from the plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan to provide you the materials and pay you up to $110.00 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court, subject to any binding arbitration requirements contained in the plan. If it should happen that plan fiduciaries misuse the plan's money, or if you are

## Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Program;
- Procedures for subrogation and reimbursement of Benefits to the Program; and
- Procedures for handling your Protected Health Information ("PHI") under HIPAA.

### General Legal Provisions Concerning the Program

***Program and Flexible Benefits Plan Documents***

This Summary presents an overview of your Benefits under one of the Program's medical coverage options, and is part of the Summary Plan Description of Best Buy's Flexible Benefits Plan. If there is any conflict between the provisions in this Summary, and any official Flexible Benefits Plan document, the Flexible Benefits Plan document shall govern.

***Relationships Among Plan Administrator, Employer Group, Claims Administrators and Providers***

The relationship between Best Buy Enterprise Services, Inc. and the Claims Administrators, and a Claims Administrator's relationships with Preferred Providers or Participating Pharmacies, are solely contractual relationships between independent contractors. Preferred Providers are not our agents or employees. Nor are they agents or employees of either Claims Administrator. Neither we nor any of our Employees are agents or employees of any Preferred Providers. None of the Plan Administrator, any member of the Employer Group or the Claims Administrators is liable for any act or omission of any Provider.

As a Claims Administrator under this Program, neither UnitedHealthCare nor Medica Self-Insured provides any health care services, supplies or drugs, nor does either of them practice medicine. Instead, each of them pays medical Benefits as Claims Administrators for the Employer Group, and UnitedHealthCare pays Prescription Drug Expense Benefits as a Claims Administrator for the Employer Group. Providers are independent practitioners who run their own offices and facilities. The credentialing process of each Claims Administrator confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided by them.

No Claims Administrator is considered to be an employer or the Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Program.

The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Program.

In addition, the Plan Administrator has delegated to the Claims Administrators the entire responsibility for making decisions on claims made by Covered Persons for medical Benefits, and any appeals they may make if a claim is denied.

Finally, the Plan Administrator has delegated to UnitedHealthCare the sole responsibility for making initial decisions on claims made by Covered Persons for Prescription Drug Expense Benefits, and for deciding any appeals they may make if a claim is denied.

***Your Relationship with Providers***

The relationship between you and any Provider is that of Provider and patient.

- You are responsible for choosing your own Providers.
- You must decide if any Provider treating you is right for you. This includes Preferred Providers you choose and Providers to whom you have been referred.
- You must decide with your Provider what care you should receive.
- Your Provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Employer Group is that of employer and Covered Employee, or that of Covered Dependent with the right to Benefits made available by the Employer Group under the Program.

***Incentives to Providers***

The Claims Administrator pays Network Providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost-efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network Providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network Providers may vary. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your Medical ID Card. They can advise whether your Network Provider is paid by any financial incentive, including those listed above. However, the specific terms of the Provider contract, including rates of payment, are confidential and cannot be disclosed.

***Incentives to You***

Sometimes a Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone, but we recommend that you discuss with your physician whether or not you should participate in any such programs. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

***Authority of Plan Administrator and Claims Administrators***

The Plan Administrator and each Claims Administrator (to the extent authorized by the Program or the Plan Administrator) has sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Program.
- Interpret the other terms, conditions, limitations and exclusions of the Program, including this Summary and any Amendments and Addendums.
- Make factual determinations related to the Program and its Benefits.

The Plan Administrator and each Claims Administrator may delegate its portion of this discretionary authority to other persons or entities who provide services for administration of the Program.

In certain circumstances, for purposes of overall cost savings or efficiency, Best Buy may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Benefits. If we do so in any particular case, that fact shall not in any way require us to do so in similar cases.

***Administrative Services***

On behalf of Sponsor, Best Buy Enterprise Services, Inc. may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Program, such as Benefit claims processing or pharmacy benefit administration. The identity of the service Providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities when they are performing their duties.

***Amendments or Termination of the Program and Flexible Benefits Plan***

Best Buy reserves the right, in our sole discretion and without your approval, to change this Program, or to interpret, modify, withdraw or add Benefits, or terminate this Program or the entire Flexible Benefits Plan. Any Amendment of this Program is effective on the date we specify in the Amendment. If the Program is amended, Covered Persons may be subject to altered coverage and Benefits.

If any provision of the Program conflicts, on its effective date, with the requirements of federal statutes or regulations, or any state law provisions that are not preempted by ERISA and apply in a jurisdiction in which the Program is operated, that Program provision is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change to this Program, the Flexible Benefits Plan, this Program's Benefits or their terms and conditions, in whole or in part, shall be made solely in a written Amendment to this Program or the Flexible Benefits Plan, which may be either prospective or retroactive, adopted in accordance with procedures established by us. Covered Persons will receive notice of any material modification to the Program. No one has the authority to make any oral modification to this Summary.

Any termination of this Program or the Flexible Benefits Plan shall be made solely in a written resolution adopted by Best Buy's Board of Directors or any committee to whom that authority has been delegated.

If this Program is terminated, Covered Persons will not have the right to any other Benefits from the Program, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Program. The amount and form of any final benefit you receive will depend on any Program document or contract provisions affecting the Program and Plan Administrator decisions.

***Clerical Error***

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors may include, but are not limited to, providing misinformation on eligibility, Benefits, coverage or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including a Claims Administrator, in accordance with the terms of this Summary and other Program documents.

***Information and Records***

At times we or a Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Program. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

When you enroll in and accept Benefits under the Program, you authorize and direct any person or institution that has provided services to you to furnish us or a Claims Administrator with all information or copies of records relating to the services provided to you, but only to the extent permitted under the Program's confidentiality procedures at the end of this Section 9. We or either Claims Administrator has the right to request this information at any reasonable time in accordance with those procedures. This applies to all Covered Persons, including Covered Dependents. We and the Claims Administrators agree that such information and records will be considered confidential as required by those procedures, the federal law called HIPAA and any applicable state law.

To the extent permitted by those laws and the Program's confidentiality procedures, we or either Claims Administrator has the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Program, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Program, we, the Claims Administrators and our related entities may use and transfer the information gathered under the Program for research and analytic purposes, to the extent permitted by applicable laws and the Program's confidentiality procedures.

For complete listings of your medical records or billing statements, we recommend that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Program, the Plan Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records through a Claims Administrator.

In some cases, the Plan Administrator or a Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary, in accordance with the Program's confidentiality procedures. Anyone designated in that way has the same rights to this information as a Claims Administrator.

***Workers' Compensation not Affected***

Benefits provided under the Program do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

**Medicare Eligibility**

Benefits under the Program are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for (or enrolled in) Medicare may also be enrolled under the Program.

***If you are eligible for (or enrolled in) Medicare, please read the following information carefully.***

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits are due under the Program), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage and, if the Program is the secondary payer as described in *Section 7*: *Coordination of Benefits*, the Claims Administrator will pay Benefits under the Program as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan on a primary basis (Medicare pays before Benefits are due under the Program), you **should** follow all rules of that plan which require you to seek services from that plan's participating Providers. When the Program is the secondary payer, the Claims Administrator will pay any Benefits available to you under the Program as if you had followed all rules of the Medicare+Choice plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

**Limitation of Legal Actions**

You cannot bring any legal action against us, either of the Claims Administrators or the Flexible Benefits Plan for any reason unless you first complete all the steps in the claims and appeal process described in Sections 5 and 6 of this Summary. After completing that process, if you want to bring a legal action against us or a Claims Administrator you must do so within 180 days after the date you are notified of a reviewer's final decision on your appeal, or you lose any rights to bring such an action against us, either Claims Administrator or the Flexible Benefits Plan.

**Subrogation and Reimbursement**

Generally, "subrogation" is the substitution of one person or entity in the place of another, to pursue the other's lawful claim, demand or right. If a Covered Person receives a Benefit payment from the Program for an Injury caused by a third party, and the Covered Person becomes entitled to any payment for that same condition or Injury from the third party or someone else (such as an insurance company), we have the right to recover from the Covered Person (or the party required to make that payment) any Program payments we made for that Injury.

Under this Program, subrogation is the process of obtaining that Benefit reimbursement from amounts payable to a Covered Person by others as a result of an Injury. If we decide to pursue subrogation for an Injury suffered by a Covered Person, the Covered Person may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made for that Injury. As a condition of participation in the Program, Covered Persons agree to provide us all assistance necessary for our subrogation claims, including cooperation and information submitted to or supplied by any insurer that provided workers' compensation or liability insurance, medical benefits, no-fault insurance or school insurance coverage that provides or is obligated to pay benefits for the Covered Person's Injury.

We shall be subrogated to (that is, will be entitled to) all of a Covered Person's rights of recovery, under any legal theory for the reasonable value of services and Benefits we provided to the Covered Person, from any or all of the following:

- Third parties, including any person alleged to have caused the Covered Person to suffer an Injury or other damages.
- The Covered Person's employer.
- Any person or entity obligated to provide benefits or payments to the Covered Person, including benefits or payments for underinsured or uninsured motorist protection. In the following provisions of this Section dealing with *Subrogation and Reimbursement*, these third parties and other persons or entities are together called "Third Parties."

Each Covered Person agrees as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus our reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after your need for services or Benefits under the Program.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That, regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The amount we are entitled to collect is the reasonable value of services provided for you under the Program.
- To hold in trust, for our benefit under these subrogation provisions, any proceeds of a settlement or judgment described in the preceding sentence.
- That we shall be entitled to recover from you the reasonable attorney fees we incur in collecting any such proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us, without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such other help (including responding to requests

for information about any accident or injuries and making court appearances) as we may reasonably request from you.

- We will not be required to pay fees, costs or expenses you incur for any claim or lawsuit, without our prior written consent.

**Refund of Overpayments**

If we incorrectly pay any Benefits for expenses incurred on account of a Covered Person, that Covered Person (or any other person or entity that was paid) must pay us a refund if either of the following apply:

- All or some of the expenses were not paid by the Covered Person, or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits due under the Program.

The refund must equal the amount we paid in excess of the amount we should have paid under the Program. If the refund is due from another person or entity, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or entity that was paid, does not promptly refund the full amount to us, we may reduce the amount of any future Benefits that are payable for the Covered Person under the Program. The reductions will equal the amount of the required refund. We may have other rights in addition to our right to reduce future Benefits.